MEDICARE PRESCRIPTION DRUG PLANS

SECTION I

MEDICARE PRESCRIPTION DRUG PLANS

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2004 (MMA) established a voluntary outpatient prescription drug benefit for Medicare beneficiaries, known as Part D. All 43 million Medicare beneficiaries are eligible to enroll in these drug plans. Drug coverage is offered through private plans approved by Centers for Medicare and Medicaid Services (CMS). Medicare prescription drug coverage helps you pay for both brand name and generic drugs. To get a Medicare prescription drug coverage you must choose and join a Medicare drug plan.

This drug benefit is offered through 2 types of private plans: stand-alone prescription drug plans (PDP) and Medicare Advantage Plans (MAPD).

- Medicare PDP adds coverage to Original Medicare, some Medicare Private-Fee-for-Service (PFFS) plans that don't offer Medicare drug coverage, some Medicare Cost Plans, and Medicare Medical Savings Account Plans.

- Many Medicare Advantage plans, such as HMO's and PPO's include coverage for prescription drugs. You will generally receive all your health care and drug coverage through your plan.

After you join the Medicare PDP of your choice, the plan will mail you membership materials including a member's card. You will use this card when you get your prescriptions filled.

Are All Drug Plans the Same?

Medicare drug plans vary based on which drugs are covered, what your out-of-pocket costs will be and which pharmacies you can use. When considering a Part D plan keep four points in mind: Coverage, Cost, Convenience, and Peace of Mind.

Coverage
Medicare drug plans cover generic and brand-name drugs. All plans must cover the same categories of drugs, but plans can choose what specific drugs are covered in each drug category.

Cost
Monthly Premiums and your share of the cost of your prescriptions vary depending on which plan you choose. If you have limited income and resources, you may qualify for Extra Help in paying your drug costs, through the Social Security Administration (SSA).

Convenience
Drug plans must contract with pharmacies in your area. Check with the plan to make sure the pharmacies in the plan are convenient to you. Some plans allow you to get your drugs through mail order.

Peace of Mind
Even if you don't take a lot of prescription drugs now, you still should consider joining a drug plan. As we age, most people need prescription drugs to stay healthy.

How Do I Find the Drug Plans in My Area?
Information about specific drug plan is included in the *Medicare & You* handbook. You can also get this information online at www.medicare.gov or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

How Much Will My Drug Coverage Costs?
Your cost will depend greatly on your prescription drug and the drug plan your choose. Costs you will incur with a drug plan include:

- **Monthly Premium** - Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium. It is possible that some plans charge no premium.

- **Yearly Deductible** - This is the amount you pay for your prescription before your plan begins to pay. Some plans charge no deductible, this may affect the monthly premium.

- **Co-payments or Coinsurance** - Amounts you pay for your prescription after you meet your deductible. Co-payments refer to specific dollar amount; coinsurance is the percentage of the drug cost.

- **Coverage Gap (the Donut Hole)** - Some plan have a coverage gap. This means that after you have spent a certain amount of money for you covered drugs. You will have to pay 100% of the drug costs. This includes your deductible, co-payments and coinsurance. This amount does not include your monthly premium. The most you will have to pay out-of-pocket in the coverage gap is $3,453.75. There are plans available that offer some coverage during the donut hole. Coverage during the gap will also affect the premium.

- **Catastrophic Coverage** - Once you have reached your plan's out-of-pocket limit, you will have "catastrophic coverage." This means that you will only pay a coinsurance amount (5% of the drug cost) or co-payment ($2.40 generic; $6.00 brand-name) for the rest of the calendar year.

How Do I Pay My Monthly Premiums?

In general, there are three ways to pay your premiums:

- You can have the premium deducted every month from your Social Security benefits.

- You can have the plan send you a bill each month. Many times the plans will bill quarterly.

- You can give permission to the plan to have your premiums automatically deducted from a savings or checking account, or charged to a credit or debit card.

If your drug coverage is through a Medicare Advantage Plan, the monthly premium you pay to the plan may include an amount for drug coverage.

What if I Cannot Afford a Drug Plan?

There is help available for those beneficiaries who need it most. If you have limited income and resources, you may qualify for Extra Help to pay for your Medicare prescription drug costs. If you qualify, you will receive help in paying your monthly premiums, and possibly your deductible, co-pays, coinsurance and coverage during the donut hole (coverage gap).

Ways You May Qualify for Extra Help

You may automatically qualify for Extra Help and do not need to apply.

- You have Medicare, full Medicaid coverage and live in a nursing home.
- You have Medicare and full Medicaid.
- You get help paying your Medicare premiums from the Medicare Saving Program (QMB, SLMB, QI).
- You have Medicare and receive Supplemental Security Income (SSI), but not Medicaid.

Each month, Medicaid will send verification of the previously mentioned categories.

If your annual income is $15,840 or less ($21,240 if married and living with your spouse) and your resources are $12,510 or less ($25,010 if married and living with your spouse), you may still qualify for Extra Help. You will need to apply. You can do this by calling the Social Security Administration (1-800-772-1213), visit www.ssa.gov on the web or apply at your local Medicaid office.

See the charts on following pages for details of Extra Help.

2010 Medicare Prescription Drug Benefit (Part D)
Eligibility & Enrollment Chart for Indiana

IF YOU HAVE…	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
No Medicare Coverage	You are not eligible for Medic*are* Prescription Drug Benefits	N/A	**N/A**	Call SHIIP 1-800-452-4800	N/A
Medicaid Only	You are not eligible for Medic*are* Prescription Drug Benefits	N/A	**N/A**	Medi*caid* will continue to cover your prescriptions	N/A
Medicaid & Medicare (Dual-Eligible) **AND:** Yearly Income below $10,640 (single) or $14,240 (married) **OR:** Yearly Income above $10,640 (single) or $14,240 (married)	You are eligible for Extra Help No premium No deductible No gap in coverage → $1.10 - $3.20 co-pay for prescriptions → $2.40 - $6.00 co-pay for prescriptions	**New to Medicare** You will be auto-enrolled in a plan for coverage first day of Medicare entitlement unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Medicaid** You will be auto-enrolled into a plan if you are not already in a drug plan. Coverage will be retroactive to the month your Medicaid coverage began.	CMS will notify you by mail if you are to be auto-enrolled. (CMS—Centers for Medicare & Medicaid Services)	You do <u>not</u> need to apply for Extra Help. You are already eligible.	**New to Medicare** - You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Medicaid** - If you are auto-enrolled into a plan that does not cover your medication you may switch plans.

IF YOU HAVE…	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
Medicare Savings Program **QMB, SLMB, or QI** (Medicaid helps pay for your Medicare) **AND**… Yearly income below $10,640 (single) or $14,240 (married) Yearly income above $10,640 (single) or $14,240 (married)	You are eligible for Extra Help No premium No deductible No gap in coverage → $1.10 - $3.20 co-pay → $2.40 - $6.00 co-pay	**New to Medicare** - You will be auto-assigned (or facilitated) plan unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Extra Help -** If you do not already have a drug plan you will be facilitated into a plan and notified of the effective date.	CMS will notify you by mail if you are to be facilitated into a plan.	You do <u>not</u> need to apply for Extra Help. You are already eligible.	**New to Medicare** You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Extra Help -** If you are facilitated into a plan that does not cover your medication you may switch plans.
Medicare with no prescription coverage Yearly income below: $14,280 (single) or $19,140 (married) **AND** Resources less than $8,100 (single) or $12,910 (married)	You are eligible for Extra Help, but you must <u>apply</u>. No premium No deductible No gap in coverage $2.40 or $6.00 co-pay	**New to Medicare** - You will be auto-assigned (or facilitated) plan unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Extra Help -** If you do not already have a drug plan you will be facilitated into a plan and notified of the effective date.	CMS will notify you by mail if you are to be facilitated into a plan.	Apply for Extra Help Select and enroll in a Drug Plan. You may want to also apply for the Medi*care* Savings Program if your resources are below $4,000 or $6,000 if married.	→ Any time → **New to Medicare** You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Extra Help -** You may choose your own plan prior to facilitated enrollment.

IF YOU HAVE…	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
Medicare with no prescription coverage Yearly income below $15,840 (single) or $21,240 (married) **AND** Resources less than $12,510 (single) or $25,041 (married)	You are eligible for Extra Help, but you must apply. $60 deductible 15% co-pay No gap in coverage Sliding Scale Premium * (see chart below)	**New to Medicare** - You will be auto-assigned (or facilitated) plan unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Extra Help -** If you do not already have a drug plan you will be facilitated into a plan and notified of the effective date.	CMS will notify you by mail if you are to be facilitated into a plan.	Apply for Extra Help Select and enroll in a Drug Plan	→ Any time. → **New to Medicare** You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Extra Help -** You may choose your own plan prior to facilitated enrollment.

If your income is:	Single Income	Married Income	What you will pay in monthly premium
135% FPL or lower	Below $14,280	Below $19,140	0% of the premium
135% - 140% FPL	$14,280 - $14,800	$19,140 – $19,840	25% of the premium
140% - 145% FPL	$14,800 - $15,320	$19,840 - $20,540	50% of the premium
145% - 150% FPL	$15,320 - $15,840	$20,540 - $21,240	75% of the premium

IF YOU HAVE…	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
Medicare but your income and/or resources are above the Medicare Prescription Drug Benefit limits for Extra Help…	You are not eligible for Extra Help. • Est. $35/mo premium • $295 deductible • gap in coverage from $2,700 to $6,153.75 in drug expenses • After gap, you pay greater of 5% or $2/40 $6.00 co-pay	You will need to enroll in a Drug Plan	**N/A**	Consider selecting and enrolling in a Drug Plan	November 15 through December 31
Medicare with other prescription coverage	Your current prescription drug coverage may or may not change.		N/A	**Consider whether you should keep current coverage or enroll in the Medic*are* Prescription Drug Benefit	See chart below

****Medigap Policy** (Medi*care* Supplement Policy)	If you have a Medigap policy with prescription drug coverage, it may or may not continue in 2006. **Contact your insurance company for information.** Your insurance company must notify you by 11/15/05 whether or not your coverage is as good as or better than the Medicare Prescription Drug Benefit, and when late penalties would apply if you choose to enroll in a Drug Plan later.
****Retirement Insurance Plan**	Your retirement insurance plan may or may not change in 2006. **Contact your plan for information.** Your insurance company must notify you by 11/15/05 whether or not your coverage is as good as or better than the Medicare Prescription Drug Benefit, and when late penalties would apply if you choose to enroll in a Drug Plan later.
****HoosierRx** (IN State Pharmaceutical Assistance Program)	HoosierRx members will receive a letter about changes to the HoosierRx program in October 2005. Call Indiana's Pharmaceutical Assistance Program toll-free at 1-866-267-4679 for more information.
****VA Prescription Benefits** (Veteran's Administration)	If you receive VA Prescription Drug Benefits, you do not need to enroll in a Medicare Prescription Drug Plan. You will not have a late penalty if you decide to enroll later.

Whose Income and Resources Count?

Your income and resources are counted. If you are married and live with your spouse, both of your incomes and resources are counted even if only one of you is applying for Extra Help. If you are married but do not live with your spouse when you apply, only your income and resources are counted.

What Counts as Income?

Income is any cash or service that can be used to meet your needs.

Countable income includes, but is not limited to the following:

- Wages
- Earnings from self-employment
- Social Security or Railroad Retirement Benefits
- Veterans Benefits
- Pensions
- Annuities
- Alimony
- Rental Income
- Worker's Compensation

Income not counted:

- Income tax refunds
- Assistance based on need funded by a state or local government
- Foster care payments
- The value of expenses which a blind or disabled person needs to work

What Resources Are Counted?

The resources counted in deciding if you qualify for Extra Help include cash and others things that can be converted into cash within 20 days.

Types of resources counted include, but are not limited to:

- Savings, checking, and money market accounts
- Certificates of Deposit (CD's)
- Retirement accounts, such as IRA or 401K accounts
- Stocks, Bonds, Savings Bonds
- Mutual Fund Shares
- The equity value of property that is not connected to your home

Resources Not Counted:

- Life insurance policies you own with a combined face value of $1,500 or less ($3,000 or less if married).
- The home you live in and the land it is on.
- Resources such as family heirlooms, wedding/engagement rings.
- Property of a trade or business which is essential to your means of self-support.
- Non-business property which is essential to your means of self-support.
- Funds received and saved to pay for medical and/or social services.

How Long Will I Receive Extra Help?

If you qualify for Extra Help, the decision remains in effect for the calendar year as long as you are enrolled in a PDP and you do not have a change in your marital status. Changes in marital status include:

- Marriage
- Divorce
- Annulment
- Separation (not temporary)
- You and your spouse resume living together
- Death of a spouse

Any of the changes to your marital status mentioned could cause the amount of your Extra Help to increase, decrease or end. You should notify SSA of any changes in your status.

What if My Application Is Denied?

You have the right to appeal the decision. To request an appeal, call SSA toll free at 1-800-772-1213. You can also get a copy of the form SSA-1021, "*Appeal of Determination for Help with Medicare Prescription Drug Costs*" from www.ssa.gov on the web.

If you want to file an appeal remember the following:

- You have 60 days to ask for an appeal.
- The 60 days start the day after you receive your letter from SSA denying your application. SSA will assume you received the letter 5 days after the date on the letter.
- You can have a lawyer, friend or someone else help you.

Choosing a Drug Plan

Everyone on Medicare has a decision to make about prescription drug coverage. If you are new to Medicare and have prescription drug coverage, you have new choices to consider. If you are not new to Medicare you have the opportunity to review your drug coverage and join or switch plans during Open Enrollment - November 15 through December 31 every year.

What Do I Need to Think About Before I Decide if I Need a Drug Plan?

Before you make a decision, you need to answer the following questions:

- If you have drug coverage now, is it creditable coverage (is it as good as Medicare PDP)? Your current plan can tell you.
- If you have drug coverage now, should you keep it?
- How would a PDP affect your out-of-pocket costs?
- Are your drugs covered by plans in your area?
- Is there a particular pharmacy you want to use?
- Do you spend part of each year in another state?
- Does the plan you're interested in offer national coverage?

When Can I Enroll in a Plan?

If you are new to Medicare you have a **7 month Initial Enrollment Period**. This period begins 3 months prior to the month your Medicare coverage begins, the month your Medicare coverage begins, and ends 3 months after the month your Medicare coverage begins. This is the case if you are eligible for Medicare due to age or disability.

Every November 15 through December 31, you will have an Annual Open Enrollment. You may join or switch to any PDP or MAPD you choose. There are situations that will allow you to have a **Special Enrollment Period (SEP)**. These include:

- Extra Help (low income subsidy - LIS) redetermination beneficiaries - Those who have lost their Extra Help as a result of the redetermination process. They will have one SEP through March.

- Change in residence - Those who move out of their service area will have a SEP of 63 days.

- Contract Violations - If the PDP violates or drastically alters their plans, you have one SEP to select a new PDP.

- Non-renewals or terminations - Individuals affected by PDP leaving the area or leaving Medicare will have an SEP.

- Involuntary loss of coverage - Individuals who lose creditable coverage, including a reduction in the level of coverage so that it is no longer creditable. This is a one time SEP to join a Part D plan.

- Not adequately informed about creditable coverage - Individuals who were not adequately informed of creditable coverage by their current plan (i.e. retirement drug coverage) will have a one time SEP granted on a case-by-case basis.

- Enroll in or maintain other creditable coverage - Individuals may disenroll from a PDP or MAPD to enroll or maintain other creditable coverage (i.e. TRICARE or VA coverage).

- Error by Federal Employee - Enrollment or disenrollment due to an action, inaction or error by a federal employee. This one time SEP is granted on a case-by-case basis and permits one enrollment or disenrollment.

- Employer Group Health Plan - Those enrolling in an employer group/union sponsored Part D plan, disenrolling from a Part D plan to take employer coverage of any kind, or disenrolling from Employer/union sponsored coverage to enroll in a Part D plan.

- CMS Sanction - Those who want to disenroll from a PDP as a result of a CMA sanction against the company they currently have a plan. This SEP is granted on a case-by-case basis.

- Cost Plan - Enrollees of a HMO or CMP plan that is not renewing their cost contracts.

- PACE (Programs of All-inclusive Care for the Elderly) - Individuals enrolling in PACE. This is a one time SEP. Currently there are no PACE plans in Indiana, but surrounding states offer PACE plans.

- Institutional Individuals - Those who move into or out of an institution such as skilled nursing facility, long term care hospital, etc.

- Medicare Entitlement Determination is made retroactively - Individuals whose Medicare entitlement is determined retroactively and who should have been provided an opportunity to enroll in a PDP during their initial enrollment period.

- Individuals who enroll in Part B during General Enrollment Period - Those who are not entitled to Part A premium free and who enroll in Part B during General Enrollment (January 1 through March 31 each year).

- New LIS Eligibles - Those who are not currently in a Part D plan and who have newly qualified for Extra Help.

- SPAP (State Pharmacy Assistance Programs) - In Indiana The SPAP is HoosierRx. Those who belong to a qualified SPAP may make one enrollment choice at any time through the end of the year.

- Full benefit dual eligibles with retroactive uncovered months - full benefit dual eligibles who enroll in a Part D plan in the months before they would be auto-enrolled.

Late Enrollment Penalty

If you do not enroll in a Part D plan when you are first eligible you may have to pay more for your monthly premiums if you enroll at a later date. The penalty is calculated at 1% for every month you did not have a Part D plan, but were eligible. The percentage is based on the national average benchmark premium. For 2010 this benchmark is $30.36 The 1% equals $0.31.

What Do Plans Look Like?

Plans vary based on formularies, cost share structure, and price. All plans must meet the standard benefits.

Standard Benefits for 2010 are as follows:

- **Deductible** - You pay 100% of the first $310.
- **Partial Coverage** - After you pay the $310 Deductible you pay 25% and your plan pays 75% until a total of $2,830 is reached. Then you enter the “Gap”.
- **Coverage Gap (Donut Hole)** - When you have paid a total out of pocket amount of $4,550, including what you paid before reaching the Gap and what you have paid during the Gap, (but not including monthly premiums), you are out of the GAP and into the Catastrophic Coverage part of your Part D Plan.
- **Catastrophic Coverage** - Once you have spent $4,550 out of pocket you will pay 5%, or co-payments of $2.40 generic: $6.00 brand name, which ever is greater. You will pay this for the reminder of the calendar year.

Plans can and do vary their coverage. Some plans do not charge either all of part of the deductible of $310. A few offer some coverage during the Donut Hole/Gap. To compare plans visit www.medicare.gov and use the Plan Compare, or call 1-800 Medicare (1-800-633-4227).

See examples on the next page of plans that could be offered.

Introducing No Brand Insurance Company's Medicare Prescription Drug Plans

What You Would Pay. . .	*The Red Plan*	*The White Plan*	*The Blue Plan*
For the first $310	Deductible: $310	Co-pay: Generics...$10 Brand Name Drugs.....$30	Co-pay: Generics....$0 Brand Name Drugs.....$25
For the next $2,700	Coinsurance: 25%	Co-pay: Tier 1.....$0 (Generics) Tier 2.....$15 Tier 3.....$30 Tier 4.....15% Coinsurance	Co-pay: Tier 1.....$0 (Generics) Tier 2.....$10 Tier 3.....$20 Tier 4.....10% Coinsurance
For the next $3,453.75 (Benefit Gap)	100% of the total drug cost	Co-pay: Generics...$25 100% of total drug costs for brand name drugs	Co-pay: Tier 1.....$10 (Generics) Tier 2.....$25 Tier 3.....$60 Tier 4.....50% Coinsurance
For the remainder of the year (Catastrophic Coverage)	$2.40 for generic drugs: $6.00 for brand name drugs; or 5% of total drug cost	$2 for generic drugs; $5 for brand name drugs; or 5% of total drug cost	$2 for generic drugs; $5 for brand name drugs

NOTE: This plan information is fictitious and is not intended to represent any actual Medicare Prescription Drug Plan available. It is for SHIP training purposes only.

What Types of Drugs Are Covered?

All Part D plans must make sure that you can receive medically-necessary drugs. Plans can use Formularies, Prior Authorization and Quantity Limits to design their drug plans.

Formularies

Drugs that are covered are included on the plans formulary or list of approved drugs. Drug plans may cover both generic and brand-name drugs. Drug lists must include a range of drugs in the prescribed categories and classes. To lower costs, many plans place drugs into different tiers, which cost different amounts. (See chart on previous page for examples). If a plan changes a drug on its list to a more expensive tier; or places a prior authorization, step therapy or quantity limit requirement on a drug, the plan will notify you at least 60 days before the change is effective.

Prior Authorization

Plans may have rules that require prior authorization before it will cover a drug. Your doctor will first have to contact the plan and show that there is a medically-necessary reason you must have this drug. Plans can have their own forms that need to be filled out to request a prior authorization.

Step Therapy is a type of prior authorization. With step therapy, in most cases you must first try certain less expensive drugs. However, if you have already tried the drugs and they did not work, or your doctor believes that because of your medical condition it is medically-necessary for you to be on a step therapy drug, he can contact the plan to request an exception.

Quantity Limits

For safety and cost reasons, plans may limit the quantity of drug that they cover over a certain period of time. For example, people prescribed Nexium should take one tablet a day. Therefore, a plan may only cover 30 tablets for a 30 day supply. If your doctor believes that because of your medical condition a quantity limit isn't medically appropriate for you, you or your doctor can contact the plan for an exception.

Your Medicare Drug Plan Rights and Appeals

What if My Plan Won't Cover a Drug I Need?

You have the right to ask for a decision called a Coverage Determination. You, your doctor or someone else you choose as your representive can call your plan or write them a letter to request that the plan cover the prescription you need. You may file a standard request or an expedited request. Your request will be expedited if your plan determines, or your doctor tells your plan that your life or health will be seriously jeopardized by waiting for a standard request. If the plan decides against you, you can appeal the decision. There are 5 levels of appeals:

- **Redetermination** - appeal through your plan; must be requested within 60 days from the date of the adverse decision; can be made in writing or over the phone; plans has 7 days for a standard request, 72 hours for an expedited request. For some types of redeterminations called exceptions, you will need a supporting statement from your doctor explaining why you need the drug your are requesting.

- **Independent Review Entity (IRE)** - must be submitted within 60 days of the adverse redetermination decision; must be in writing; once request has been filed the IRE has 7 days for a standard request, 72 hours for a expedited request.
  The IRE is MAXUMUS

- **Administrative Law Judge Hearing (ALJ)** - Must be requested in writing with 60 days of the adverse IRO decision; there is a minimum dollar amount.

- **Medicare Appeals Council (MAC)** - if you receive an adverse ALJ decision you will be advised on the process to request a review by the MAC.

- **Federal Court** - if you receive an adverse MAC decision you will be advised on the process to request a review by the a federal court.

When you join a plan you will receive information about the plan's appeal process.

How Do I File a Complaint?

You have the right to file a complaint with a plan. You should file your complaint within 60 days of the event that led to your complaint. Examples of why you might file a complaint:

- You believe your plan's customer service hours of operation should be different.
- You have to wait too long for your prescription.
- The pharmacy charges you more than it is supposed to. If you think you have been charged too much, call your plan for the up-to-date price.
- The plan does not make a determination about a coverage determination or appeal within the required time frame.
- You disagree with the plan's decision not to expedite your request for a coverage determination or first-level appeal.

You should first contact your plan with your complaint. If the plan does not take care of your complaint call 1-800 Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.